Department of Labor & Industries
Crime Victim Compensation Program
PO Box 44520
Olympia WA 98504-4520

RESET

MEDICAL CERTIFICATION OF TIME LOSS

Date of crime	Victim's name	Claim number

Current mailing address | State | ZIP | Check if address is new ☐

Last date worked	Date returned to work	Was sick leave or disability insurance paid? If yes, for what period?
/ /	/ /	Yes ☐ No ☐

If not working, state why

Have you applied for or are you receiving benefits from:
☐ Social Security ☐ Employment Security ☐ Public Assistance

	Date	Claimant's signature
	/ /	

Provider's Statement (all questions must be answered)	Most recent treatment date / /	Is treatment concluded and the condition stable? Yes ☐ No ☐
Has patient been released for work? Yes ☐ No ☐	Date released / /	Will permanent impairment result from this injury? Yes ☐ No ☐ Maybe ☐

Any physical and/or mental health restrictions?

If not released, when do you anticipate release for work? / /

Remarks:

Date	Print attending provider's name and title	Attending provider signature

TO CLAIMANT: Upon completion and return of this form, determination and payment of compensation for wage loss will be made, if indicated.
NOTE: Persons making false statements in obtaining Crime Victim benefits are subject to civil or criminal penalties under the law.

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